

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

06857

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel
Round Bay, P.O. Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 years.

Hospital, Institution, or street address where death occurred:

Luna Lane

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Elmer John Ahlhauser

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

White

Married.

6. (b) Name of husband or wife

Barochy Hambleton Ahlhauser

7. Birth date of deceased (mo. day, yr.)

June 23 - 1899

6. (c) If alive, give age

53

years

8. AGE:

Years Months Days If less than one day

49 0 14

hrs. min.

9. Birthplace

Milwaukee, Wisconsin

(Town, county, and state)

10. Usual occupation

Sales - Engineer.

11. Industry or business

Henry Ahlhauser

New York City, N.Y.

MOTHER FATHER

12. Name

Elizabed Battig

13. Birthplace

February

14. Maiden name

Henry Ahlhauser

15. Birthplace

Round Bay, Md.

16. Informant

Elizabed Battig

Address

Druid Ridge Cem.

Cemetery or crematory

Pikesville, Md.

Location

WM. J. TICKNER & SONS

18. Funeral director

Baltimore, Md.

Address

July 9, 1948

19. (Date rec'd by registrar)

A. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel Co.

City or town

Round Bay, Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Luna Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

World War #1

3. (b) Social Security Number

179-01-2030

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7, 1948, at 9 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19, 1947, to July 6, 1948,

and that I last saw him alive on July 6, 1948.

Immediate cause of death

Aortic stenosis

Due to

Mitral insufficiency

Due to

Hypertension

Other conditions

Cardiac decompensation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Glen Burnie, Md. Date signed

July 7, 1948

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. To correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

06859

27

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel

City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr 31 minutes

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 1 hr 31 minutes

3. (a) FULL NAME
ELIZABETH ANN
BEACH BABY GIRL

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced --

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 17 JULY 1948 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
1 hrs. 31 min.

9. Birthplace Fort Geo. G. Meade, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name Gordon Leroy Beach
13. Birthplace Wisconsin

MOTHER 14. Maiden name Else Styri
15. Birthplace Norway

16. Informant Lt. Col. Gordon L. Beach
Address Ft. George G. Meade, Md.

17. Burial Date thereof 19 July 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Post Cemetery

Location Fort George G. Meade, Maryland

18. Funeral director Lilly & Zeiler, Inc.
Address Eastern Ave, Baltimore, Maryland

19. 19 July 1948 Date rec'd by registrar
AMTS N. GOERGER, Capt. (Date signed) 17 July 48
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2223 Rockwell Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 July 1948, at 10:55 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 0844 17 July 1948 to 1015 hrs 17 Jul 48

and that I last saw h. alive on 19.

Immediate cause of death Premature Birth DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE HENRY M. FOSTER, Capt. D. M. C. G.

MSC Ft. George G. Meade, Md. Date signed 17 July 48

RECEIVED

JUL 20 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 21

C6860

93d

CERTIFICATE OF DEATH

M
Dr. Finkardt
The correct age
is especially important.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 hrs.

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?..... 6 hrs.

3. (a) FULL NAME

MINNETTA SARAH ELIZABETH BEAVIN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Everett E. Beavin

7. Birth date of deceased (mo. day, yr.)

Feb. 18, 1875

8. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

73

5

6

hrs.

min.

9. Birthplace

Prince George County, Maryland
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Henry Thomas Scott Scott.

MOTHER FATHER

12. Name

Henry Thomas Scott Scott.

13. Birthplace

Unknown

14. Maiden name

Sarah Yost.

15. Birthplace

Unknown

16. Informant

Mr Everett Beavin Sr.
Linthicum Heights, Maryland

17. Burial

Date thereof..... July 27, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cedar Bluff Cemetery

Location..... Annapolis, Maryland

18. Funeral director

Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland19. July 27, 48
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 106 Adams St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24 1948 at 10:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 24 1948 to July 24 1948
and that I last saw her alive on July 24 1948

Immediate cause of death

Cerebral Hemorrhage
Hypertension C.V. Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

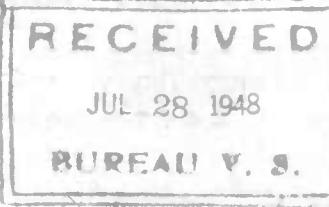
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Finkardt
M.D. or other
Address 200 Maryland Avenue
Date signed 7/24/48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CG864

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

A. a. Airport

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leo F. Bell

4. Sex

M. W.

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. Bell

(6. c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 19th 1879

8. AGE:

Years

Months

Days

If less than one day

68 8 27

hrs.

min.

9. Birthplace

Geo. Co. Md.

(Town, county, and state)

10. Usual occupation

Pet Painter at

11. Industry or business

N.S. Naval Academy

12. Name

George W. Bell

13. Birthplace

Ph. Geo Co. Md.

14. Maiden name

Virginia Scott

15. Birthplace

Ph. Geo Co. Md.

16. Informant

Mrs. Fred. Smith

Address

Arnold A. E. G. Md.

17. Burial

Burial

Date thereof July 18 1948
(month) (day) (year)

Cemetery or crematory

Asbury

Location

Arnold Md.

18. Funeral director

John M. Tay Jr. Son

Address

Annapolis Md.

19. July 18 48

Date rec'd by Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A A

City or town Airport

(If outside city or town limits, write RURAL and give nearest town)

Street No. Brancher Pt.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 15 1948 at 10²⁰ M

21. I CERTIFY that death occurred on the date above stated; that I have deceased from

Postmortem Examination
and that I last saw him alive on July 15 1948

Immediate cause of death

Acute Dilatation Heart Sudden

Due to

Chronic Myocarditis 64 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

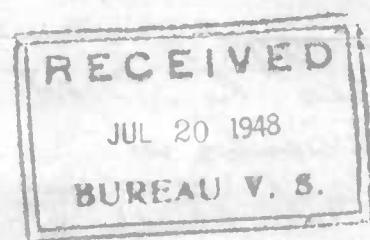
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Claffey M.D. Deputy Medical Examiner
Annapolis Md. M. D. or other
Address Date signed 7/16/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51C

06862

22

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Champions Forest

How long in hospital or institution?

3. (a) FULL NAME

MARK D. BOLLES.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W.

MARRIED

6. (b) Name of husband or wife

FERN J. BOLLES.

7. Birth date of deceased (mo., day, yr.)

AUG 8, 1908

6. (c) If alive, give age.....years

8. AGE:

Years
39Months
10Days
28It less than one day
hrs. min.

9. Birthplace

FORT DICKSON, N.Y.

(Town, county, and state)

10. Usual occupation

GOVT CLERK

11. Industry or business

SOC SEC RECORD DIVISION

12. Name

SCOTT THOR BOLLES.

13. Birthplace

14. Maiden name

ELLEN PERIGO.

15. Birthplace

PENNA.

16. Informant

MRS FERN J. BOLLES.

Address

CHAMPION FOREST, JESSOP, Md.

17. Burial

Date thereof
(month) (day) (year)
July 9, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

MEADOWRIDGE MEMORIAL CEM.

Location

BALTO-WASH BLVD. AT DODSON RD.

18. Funeral director

RICHARD G. BOLLES

Address

505 Washington Blvd., Laurel, Md.

19. Date rec'd by registrar

July 6, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Anne Arundel

City or town

Jessop

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Champions Forest

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

JULY 6 1948 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1945 to July 6, 1948

and that I last saw him alive on

Immediate cause of death

Abnormal

Carcinomatous -

DURATION

6 mos.

Due to Seminoma, probably
testicular origin

3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

see above

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Shiley, M.D.

M.D. or other

Savage, Md.

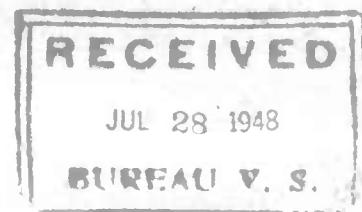
Date signed

7/6/48

60003

JUL 27 1948

JUL 27 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Purvis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06863

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Myers T. Boncher

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White Married

6. (a) Single, married, widowed, or divorced

Elyabell E. Boncher

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

January 13 1853

8. AGE:

Years 95 Months 6 Days 0 Days 13 If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore Md

10. Usual occupation

Retail Bricklayer and

11. Industry or business

Chandler

12. Name

Joseph Boncher

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. John F. Murphy

Address

84 Bondent St. Baltimore Md

17. Burial

(Burial, cremation, or removal, Where)

Date thereof July 24 1948
(month) (day) (year)

Cemetery or crematory

A Anne

Location

Baltimore Md

18. Funeral director

John W. Layton Son

Address

Baltimore Md

19. July 22 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Baltimore Md

Street No. 84 Bondent

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21st 1948 a.m. 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 10 1948 to July 21 1948
and that I last saw him alive on July 20 1948

Immediate cause of death

Uremia

Due to Robert Schlosser

Due to G. H. Hinkley

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

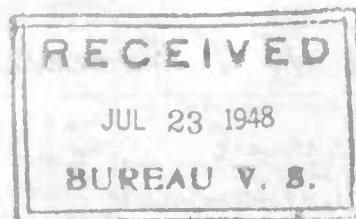
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Purvis
Anne Arundel
Date signed July 21/48
M. D. or other
Address



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06854

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
Anne Arundel
County.....

City or town.....
Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 yrs.

Hospital, Institution, or street address where death occurred:

902 Bay Ridge Ave.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland
County..... Anne Arundel

City or town.....
Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 902 Bay Ridge Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

PASQUALE BOVE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife..... Lucia Bove

7. Birth date of deceased (mo., day, yr.) April 11, 1868
..... 6. (c) If alive, give age..... 91 years

8. AGE: Years Months Days If less than one day
80 3 21 hrs. min.

9. Birthplace..... Italy
(Town, county, and state)

10. Usual occupation..... Ret.

11. Industry or business..... Shoemaker

12. Name..... Carmen Bove

13. Birthplace..... Italy

14. Maiden name..... Theresea Marinaro

15. Birthplace..... Italy

16. Informant..... Mr. Charles Bove

Address..... Eastport Post Office, Eastport, Md.

17. Burial..... Date thereof..... 8-2-48
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St Mary's Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... Ben L. Hopping and Son

Address..... 170-172 West St. Annapolis, Md.

19. Date rec'd by registrar..... August 2, 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 31 1948 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1948 to July 31 1948 and that I last saw him alive on July 31 1948

Immediate cause of death..... Cervical Hemorrhage
DURATION 3 days

Due to..... Arterio Sclerosis

Due to.....

Other conditions..... Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

Frank C. Bove
Annapolis, Md. M. D. or other
Date signed..... August 2, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

06865

21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: 36 South Street
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 36 South Street
 (If rural, give LOCATION)

3. (a) FULL NAME
 Estelle Chase

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6. (b) Name of husband or wife..... Arthur Chase

7. Birth date of deceased (mo., day, yr.) August 18, 1897

8. AGE: Years 50 Months 11 Days 13 If less than one day hrs. min.

9. Birthplace..... Annapolis, Maryland

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

12. Name..... Jacob Carpenter

13. Birthplace..... Anne Arundel, Co. Md.

14. Maiden name..... Rebecca Hampton

15. Birthplace..... Anne Arundel, Co. Md.

16. Informant..... Blanche Carpenter

Address..... 72 Franklin Street

17. Burial..... Brewer Hill Cemetery

(Burial, cremation, or removal. Which?) Cemetery or crematory

Location..... West Street Extended

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 43-45 Northwest Street

19. Date rec'd by registrar..... August 4, 1948

VS A15

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 31, 1948, at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1947, to July 31, 1948, and that I last saw her alive on July 17, 1948.

Immediate cause of death..... Cancer of breast with metastasis of vital organs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

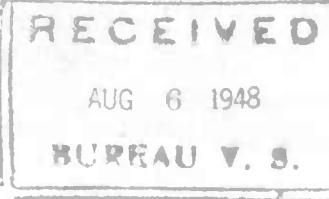
Injured at work?

23. SIGNATURE..... G. T. Allen M.D.

M. D. or other.....

Date signed..... 8-1-48

Registrar



Evidence for correction
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

AM No. G 117 SEP 16 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 21

93a
06866

1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 Yrs.

Hospital, institution, or street address where death occurred:

38 Cornhill Street

How long in hospital or institution?

3. (a) FULL NAME

Issiah Chase

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Alice Chase

7. Birth date of
deceased (mo., day, yr.)

October 1, 1883

6. (c) If alive, give age 62 years

8. AGE:

Years
65 64

Months
9

Days
18

If less than one day
hrs. min.

9. Birthplace

Waterbury, A.A.C. Co. Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

None

MOTHER FATHER

Daniel Chase

13. Birthplace

Anne Arundel Co. Md.

14. Maiden name

Frances Waters

15. Birthplace

Anne Arundel Co. Md.

16. Informant

Alice Chase

Address

38 Cornhill Street

17. Burial

Date thereof 7-22-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brewer Hill Cemetery

Location

West Street Extended

18. Funeral director

Mrs. Charles E. Hicks

Address

43-45 Northwets Street

19. Date rec'd by registrar

July 21 1948

7-21-48
J. E. Brumich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel Co.

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

38 Corn hill Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19, 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6, 1948, to July 19, 1948, and that I last saw him alive on July 19, 1948.

Immediate cause of death

Obituary - Myocardial

Due to

Obituary - Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

City or town

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

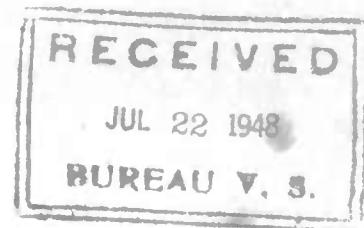
J. E. Brumich

M. D. or other

Address

110 - 4th St., Owings Mills

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

06862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Anne Arundel
Galesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Henry Cherry

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

1890?

6. (c) If alive, give age..... years

8. AGE:

Years
58

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

William Woodfield

Address

Galesville Md.

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)
July 22-48

Cemetery or crematory

Quaker Cemetery

Location

Galesville Md

18. Funeral director

F. G. Faraday & Son

Address

Galesville Md

19. (Date rec'd by registrar)

7/22/48

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Galesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

217-03-5797

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 19 1948 10³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Post mortem examination

and that I last saw him alive on 19.....

Immediate cause of death

Acute Dilatation of Heart

Due to

Cirrhosis of liver

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

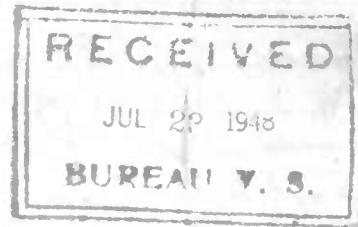
Means of injury

Injured at work?

23. SIGNATURE

Address

John M. Coffey M.D.
Medical Examiner
Anne Arundel, Md
Date signed: 7-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06868

20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County *Anne Arundel County*City or town *Bethesda - Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 months*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Mary Elizabeth Clagett -
Lulu*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

widowed

6.(b) Name of husband or wife *Chas. E. Clagett*

7. Birth date of

deceased (mo., day, yr.)

*April 17, 1879*6.(c) If alive, give age *70* years

8. AGE:

Years *69*Months *2*Days *14*

if less than one day

hrs. *0*min. *0*

9. Birthplace

Leesburg - Loudoun Co. Va.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER

FATHER

12. Name *Samuel Lulu*13. Birthplace *Washington D.C.*14. Maiden name *Ida Eckert*15. Birthplace *Washington - D.C.*

16. Informant

Rose C. Hackett

Address

Bethesda - Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *7-3-48*
(month) (day) (year)Cemetery or crematory *Union Cemetery*Location *Leesburg - Va.*

18. Funeral director

*Tom Gavett - Los Angeles, Calif.*Address *1756 Pennsylvania Ave.**7/8 48*

19. (Date rec'd by registrar)

*18. 48**M. Clayton**Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *District of Columbia*City or town *Washington - D.C.*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *The Greenbrier Apartments*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Tuesday, July 1, 1948* at *10:10 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Decatur* *1947* to *Tuesday, July 1, 1948*and that I last saw her alive on *Tuesday, July 1, 1948*

Immediate cause of death

*Carcinoma of ovary*Due to *diffuse metastasis*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

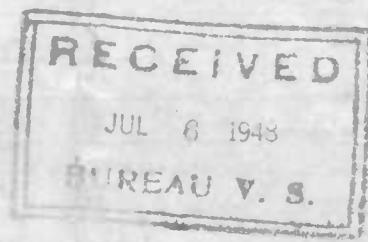
Injured at work?

23. SIGNATURE *Frank H. Wilson, M.D.*

M. D. or other

Address *Lothian - Md.* Date signed *7/1/48*

61-4-6681
61-2-14
X-X-8461
12-9



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

06869

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

dead on arrival

dead on arrival

3. (a) FULL NAME

Kate Cooke

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Nov. 15 1863?

8. AGE:

about 85

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

King George County, Virginia

(Town, County, and state)

10. Usual occupation.

- - -

11. Industry or business

- - -

MOTHER

FATHER

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mrs. Alice Main

Address

4613 Norwood St., Chevy Chase Md

17. Removal

Date thereof July 4, 1948

(Burial, cremation, or removal. Which?)

Round Hill Cemetery

Cemetery or crematory

Shiloh, Va.

18. Funeral director

Chevy Chase Funeral Home

Address

5101-Wis Anne Dr.

19. Date rec'd by registrar

July 4 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

Montgomery

City or town

Chevy Chase

Street No.

4613 Norwood Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4 1948 35 A.M.

21. I CERTIFY that death occurred on the date above stated: *Post mortem examination*

July 4 1948

Immediate cause of death

Fracture of neck

Due to

Fall down stairway

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

7-4-48

Where did injury occur?

Edgewater

A.A., Maryland

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

Mr. T.S. Lyons home

Means of injury Fall down stairway

Injured at work?

No

Deputy medical examiner

M.D. or other

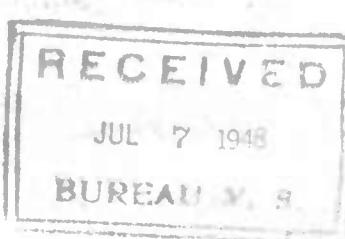
23. SIGNATURE

Address

Annapolis, Md.

Date signed

7-4-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

668

06870

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel Co.

County

Annapolis

City or town

(If outside city or town limits, write RURAL and give nearest town)

8 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:
38 College Creek Terrace

How long in hospital or institution?

3. (a) FULL NAME

Fredrick Davis Jr.

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

July 14, 1893

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Davidsonville A.A. Co. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Ned Davis

FATHER

12. Name

Ned Davis

13. Birthplace

Davidsonville A.A. Co. Md.

14. Maiden name

Margret Carroll

15. Birthplace

Davidsonville A.A. Co. Md.

16. Informant

Fredrick Davis Jr.

Address

202 Vernon Street

17. Burial

Date thereof 7-25-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Davidsonville Cemetery

Location

Davidsonville Md.

18. Funeral director

Mrs. Charles E. Hicks

Address

43-45 Northwest Street

July 23 1948

(Date rec'd by registrar)

T. B. Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 College Creek Terrace

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

213-14-9070

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21 1948, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

7-4 1948 to 7-21 1948

and that I last saw him alive on 7-21-48

1948

Immediate cause of death

Severe Psychoses
Acidosis

DURATION

Due to

Severe Psychoses

Due to

Malnutrition and
dehydration

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

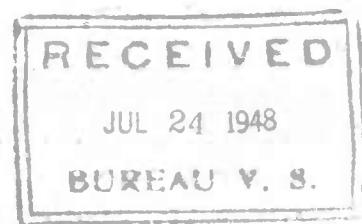
Injured at work?

23. SIGNATURE

M. D. or other

Address 10 Carroll 7-21-48 Date signed

MARGIN RESERVED FOR BINDING
I
9-45-15
VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06873

CERTIFICATE OF DEATH

97
Reg. Dist. No. 23

1. PLACE OF DEATH:

County

A.A. Co.

City or town

Quarterfield Rd. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joshua B. Donaldson

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

married

6. (b) Name of husband or wife

Mannie L. Warfield

6. (c) If alive, give age 75 years

7. Birth date of deceased (mo. day, yr.)

April 15, 1869

8. AGE:

Years
79

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Joshua Donaldson

MOTHER FATHER

12. Name

Maryland

13. Birthplace

Maryland

14. Maiden name

Mannie Charles

15. Birthplace

Maryland

16. Informant

Mrs. Mannie Donaldson

Address

Quarterfield Rd

17. Burial

Glen Burnie

Date thereof 7/29/48
(month) (day) (year)

Cemetery or crematory

Friendship

Location

Anne Arundel Co. Md.

18. Funeral director

John F. Denny Inc.

Address

715 Light St.

19. (Date rec'd by registrar)

7/29/48

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

A.A. Co.

City or town

Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Quarterfield Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27th

19. 48

at 3 $\frac{1}{3}$ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 28, to July 27th

19. 48

and that I last saw him alive on July 20th

19. 48

Immediate cause of death General and word disease

in hypotension - cerebral involvement

2 yrs

inflammation and shock -

Due to Peritonitis by rupturing to

30 days

abdomen and dying death

Due to Other

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

✓

Date of op.

Autopsy results

✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Federick V. Denny

M. D. or other

Address

723 Merriweather Ave.

Date signed

7-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

06872

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

a. *O. O. Co.*
opp. Cedarhurst (Chesapeake Bay)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*Body found at Naval Air Station
near Annapolis Md*

How long in hospital or institution?

3. (a) FULL NAME

Lawrence L. East

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

8. (c) If alive, give age years

Aug. 29 1883

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Va.

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

John East

13. Birthplace

Va.

14. Maiden name

Sarah Harris

15. Birthplace

Va.

16. Informant

Lawrence L. East

Address

803 Mass. Ave. N.E. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

7-14-48

Cemetery or crematory

Abraham Lincoln Cemetery

Location

Prince George's County, Md.

18. Funeral director

B. J. Laffell

Address

475 H. St. N.W. Wash. D.C.

19. Date rec'd by registrar

July 13 48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Washington D. C.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

733 6th Street N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

*July Unknown 48*21. I CERTIFY that death occurred on the date above stated: *1948*22. I CERTIFY that death occurred on the date above stated: *July 12 1948*

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Accidental Date of unknownWhere did injury occur opp. Cedarhurst County A. A. Md State Md

Injured at home, farm, industry, public place (where?)

Chesapeake Bay

Means of injury

*Drowning*Injured at work? ?

23. SIGNATURE

John M. Laffly M.D.

M. D. or other

Address

*Annapolis Md*Date signed *7-13-48*

RECEIVED
JUL 14 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, ~~in~~ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06871

28

Reg. Dist. No. 28

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Waterbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Edwards

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored or color

Cora Edwards

6. (b) Name of husband or wife

Deceased

7. Birth date of deceased (mo., day, yr.)

Years

Months

Days

11 less than one day

hrs.

min.

6. (c) If alive, give age years

(unknown)

1871

7. AGE: Years Months Days 11 less than one day hrs. min.

9. Birthplace

A. A.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Edward Edwards

12. Name

A. A.

13. Birthplace

A. A.

14. Maiden name

Waterbury

15. Birthplace

A. A.

16. Informant

Harry Edwards

Address

Crownsville, P.O.

17. Burial

(Burial, cremation, or removal. Which?)

John Wesley

Cemetery or crematory

Waterbury

Location

Home of Johnson

18. Funeral director

Annie G. Johnson

Address

Annapolis

19. Date rec'd by registrar

July 3, 1948

E. F. Joyce

Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Waterbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1, 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1, 1948 to July 1, 1948

and that I last saw him alive on July 1, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Arterio-Sclerotic

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

R. L. Richardson, M.D. or other

Address: 110 - 8th & Anna St., Annapolis, Md. Date signed: 7/3/48

RECEIVED

JUL 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06874

21

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 9 days.

3. (a) FULL NAME

BERNARD WILLIAM ENGELKE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Vera M. Engelke

7. Birth date of deceased (mo. day, yr.)

November 12, 1894

6. (c) If alive, give age

45

years

8. AGE:

Years

Months

Days

If less than one day

53

8

11

hrs.

min.

9. Birthplace

Eastport, A.A. Co. Maryland

(Town, county, and state)

10. Usual occupation

Welding

11. Industry or business

George Engelke

12. Name

Annapolis, Maryland

13. Birthplace

Else Harrison

14. Maiden name

Maryland

15. Birthplace

16. Informant

Mrs. Bernard Engelke

Address 165 Main Street, Annapolis, Md.

17. Burial

Date thereof July 26, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Annapolis, Maryland

18. Funeral director

Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. July 26, 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 165 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 23, 1948, at 6A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1948, to July 22, 1948

and that I last saw him alive on July 22, 1948

Immediate cause of death

Chronic myocarditis

9 mos.

Due to

Atherosclerosis

unknown

Due to

Gumma of left lung

unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURES

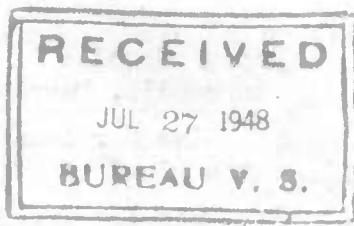
M. D. or other

Address

Date signed

Registrar

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06875

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ella May Ferguson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John W. Ferguson

6. (c) If alive, give age _____ years

May 25 1873

7. Birth date of deceased (mo., day, yr.)

1873

Years Months Days If less than one day

15 1 18 hrs. min.

9. Birthplace

Annapolis, Maryland
(Town, county, and state)

10. Usual occupation

Invalid

11. Industry or business

Frank Welch

12. Name

Pa.

13. Birthplace

Mary Logan

14. Maiden name

Annapolis, Md.

15. Birthplace

Frederick & Breckinridge

16. Informant

Address 23 Francis St. City-

17. Burial

Burial Date thereof 7-14-48
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Bluff

Location

Annapolis, Md.

18. Funeral director

John D. Taylorson

Address

Annapolis, Md.

19. Date rec'd by registrar

July 14 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis (If outside city or town limits, write RURAL and give nearest town)Street No. 23 Francis Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1948 at 11:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
left 1948 to July 12, 1948
and that I last saw her alive on July 12, 1948

Immediate cause of death

Broncho-pneumonia DURATION 2 weeksDue to Cerebral Hemorrhage with Hemiplegia 1948Due to Hypertensive Cardio-vascular disease 1948

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

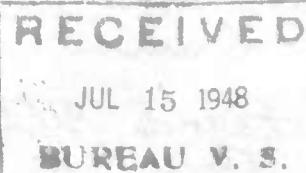
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James R. Martin, M.D. M. D. or otherAddress Annapolis, Md. Date signed 7-13-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06876

20

CERTIFICATE OF DEATH

Reg. Dist. No.

M
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Anne ArundelCity or town Galesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Foot4. Sex M5. Color or race C6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Mary Foot7. Birth date of deceased (mo., day, yr.) 9. (c) If alive, give age years 18818. AGE: Years 67 Months Days If less than one day 9. Birthplace Steadyside, A.A. Col. Ind.
(Town, county, and state)10. Usual occupation Waiting11. Industry or business 12. Name Charles Foot13. Birthplace Ind.14. Maiden name Harriet Foot15. Birthplace Ind.16. Informant Mary FootAddress Galesville, Ind.17. Burial Date thereof July 24, 1888(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dan'l Day BuryLocation West River Ind.18. Funeral director T. A. Hardisty & SonAddress Galesville, Ind.Date rec'd by registrar July 28, 1888(Date rec'd by registrar) 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind.County A.A. Co.City or town Galesville Ind.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war 3. (b) Social Security Number 317-07-3389

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1888 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13, 1888 to July 20, 1888 1888and that I last saw him alive on July 13, 1888 1888Immediate cause of death Ageing

DURATION

Due to Chapped skin

7 days

Due to Chapped skin

7 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

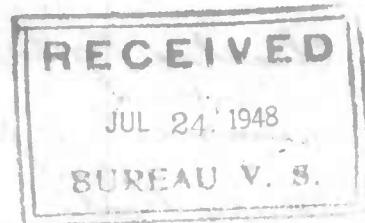
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Frederick H. Johnson M.D.

M. D. or other

Address 40 North Charles StreetDate signed July 21, 1888

1881
67
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

068727

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Fort George G. Meade, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 18 hours 24 min

Hospital, institution, or street address where death occurred: Station Hospital Fort Geo G. Meade, Md.

How long in hospital or institution?..... 18 Hours 24 min

3. (a) FULL NAME

WILLIAM EDWARD GAGNE

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male	White	-	-
------	-------	---	---

6.(b) Name of husband or wife.....

B.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... 24 July 1948

8. AGE: Years..... Months..... Days..... If less than one day
 18 hrs. 24 min.

9. Birthplace..... Fort George G. Meade, Maryland
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name..... James Gagne Jr.
 13. Birthplace..... Cheyenne, Wyo

MOTHER 14. Maiden name..... Mary Ruth Earline Still

15. Birthplace..... Spartanburg, S.C.

16. Informant..... James Gagne

Address..... Fort Geo G. Meade, Md.

17. Burial..... Date thereof..... 26 July 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... Arlington National Cemetery, Virginia.

18. Funeral director..... J. Arthur Walters

Address..... Laurel, Maryland.

19. Date rec'd by registrar..... 30 July 48

(Date rec'd by registrar)..... 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Anne Arundel

City or town..... Fort George G. Meade, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

* * *

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 25 July 1948 at 1040A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 24 July 1948 to 25 July 1948.

and that I last saw h. i.m. alive on 25 July 1948.

Immediate cause of death..... prematurity

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Norman N. Wuebel, 1ST LT M. D. or other MC
 NORMAN N. WUEBEL, 1ST LT M. D. or other MC
 USC Sta Hosp Ft Meade, Md. Date signed 25 July 48

RECEIVED BY THE GOVERNED STATE OF UTAH

RECEIVED BY THE STATE OF UTAH



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06878

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County *Brooklyn*City or town *Brooklyn - Boro. 25*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *6 yr.*Hospital, Institution, or street address where death occurred: *# 4 W. 11th Ave*How long in hospital or institution? *Brooklyn Park*

3. (a) FULL NAME

Charles Murray Giee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

Rosetta A. Giee

6. (b) Name of husband or wife

7. Birth date of

deceased (mo. day, yr.)

6. (c) If alive, give age *62* years

Mar. 3 - 1885

8. AGE:

Years

Months

Days

If less than one day

63

4

9

hrs.

min.

9. Birthplace

Baltimore *Md.*

(Town, county, and state)

10. Usual occupation

Coffee grinder

11. Industry or business

Kerr's Murray Giee

12. Name

FATHER

Kerr's Murray Giee

13. Birthplace

Baltimore

14. Maiden name

Margaret Wagner

15. Birthplace

Germany

16. Informant

Mrs. Rosetta Giee - (wife)

Address

4 W 11th Ave - Brooklyn Park

17. Burial

Date thereof *7/15/48*

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or cemetery

Woodlawn

Location

Baltimore County, MD

18. Funeral director

Wm. T. Packer & Sons

Address

Baltimore, MD

19. (Date rec'd by registrar)

19 *7-13-48*

(Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*

County

*ac*City or town *Brooklyn Park*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *440 W. 11th Ave*

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

314-0-1-7072

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 12 1948

2E. CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb. 25 1948 to July 12 1948*and that I last saw h. in alive on *July 12 - 1948*

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 1/2 hrs.

Due to

arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Chas. L. Ball, M.D.

M. D. or other

Address

*Jefferson*Date signed *7-12-48*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

06879

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Burke's Branch

City or town

Pasadena P.O. (Brook's Creek)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

a few hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Goma C. Gooch

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Theona V. Gooch

7. Birth date of deceased (mo. day. yr.)

Aug. 27th, 1913

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Dallas, Texas

(Town, county, and state)

10. Usual occupation

Radio Engineer

11. Industry or business

W B M D

MOTHER FATHER

12. Name

Francis C. Gooch

13. Birthplace

Tennessee

14. Maiden name

Debbie Ramsey

15. Birthplace

Tennessee

16. Informant

Mrs. G.C. Gooch

Address

8530 Willow Oak Ave.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

July 8th 1948

Cemetery or crematory

Parkwood

Location

Baltimore, Md.

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Rd.

19. July 7 1948

(Date rec'd by registrar)

T. W. Hedder

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Fullerton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

8512 Willow Oak Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

1455-07-9032

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

on July 5 1948

Immediate cause of death

Due to

Drowning

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-5-48
Where did injury occur? Pasadena P.O. (City or town) Brook's Creek (County)

Injured at home, farm, industry, public place (where?)

Means of injury DrowningInjured at work? No

23. SIGNATURE

John M. Gaffey M.D. Deputy Medical Examiner
Address Annapolis, Md. M.D. or other
Date signed 7-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

302

06880

27

Reg. Dia. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel
City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 year

3. (a) FULL NAME

HATTIE GREEN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	negro	married

6. (b) Name of husband or wife Douglas Green

7. Birth date of deceased (mo., day, yr.) 1908

6. (c) If alive, give age -- years

8. AGE: Years	Months	Days	It less than one day
40	---	---	--- hrs. --- min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Will Belle

13. Birthplace North Carolina

14. Maiden name Mamie Thomsen

15. Birthplace North Carolina

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial, cremation, or removal. Which? Shipped Date thereof July 10, 1948

(month) (day) (year)

Cemetery or crematory Selma North Carolina

Location

18. Funeral director Katie R. Williams

Address 322 North Schroder St., Baltimore, Md.

19. (Date rec'd by registrar) 7/10 1948

An Hedden
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 869 W. Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1948, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1947, to July 7, 1948.

and that I last saw her alive on July 7, 1948.

Immediate cause of death General Paresis

known to us since

7/19/47

Due to:

Due to:

Other conditions General Paresis

known to us since

7/19/47

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Jacob Blongerster, M.D.

M. D. or other

Crownsville, Maryland Date signed 7/7/48

Address

PLEASE WRITE PLAINLY, WITH UNFADED INK. Supply every item of information carefully. The correct age is especially important. Physician, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06881
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: H. H. COUNTY

County

City or town LAKE SHORE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 YRS.Hospital, institution, or street address where death occurred: NONEHow long in hospital or institution? —

3. (a) FULL NAME

John Gumpman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWMARRIED

6. (b) Name of husband or wife

MINNIE Rome

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

11/15/1885

8. AGE:

Years 62Months 8Days 14

It less than one day

hrs. min.

9. Birthplace

M.D.

(Town, county, and state)

10. Usual occupation.

FISHERMAN

11. Industry or business

12. Name JOHN GUMPMAN13. Birthplace M.D.14. Maiden name KUNIDUNDA WIEMAN15. Birthplace M.D.16. Informant MINNIE GUMPMANAddress R.F.D. 1 LAKE SHORE, Md.17. Burial BURIALDate thereof 8/21/48
(Burial, cremation, or removal, Which?)
(month) (day) (year)Cemetery or crematory ABLY CROSSLocation RITCHIE HIGHWAY18. Funeral director LILLY & ZEILER INC.Address 403 S. WOLFE ST. 3119. Aug 2 1948 As M. H. Gumpman
(Date signed by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M.D.County H. H. COUNTYCity or town LAKE SHORE

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

No

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 18, 1948 to Mar. 6, 1948and that I last saw him alive on Mar. 6, 1948Immediate cause of death Acute Heart Failure

DURATION

Due to Coronary occlusion with myocardial infarctionDue to coronary sclerosisOther conditions Hypertension; cardiac hypertrophy
(Include pregnancy within 3 months of death)Major findings of operations NoneDate of op. —Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NoneAccident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE A. F. Gumpman M.D.

M. D. or other

Address Pasadena, Md.Date signed July 29, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06882

93d

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Anne Arundel Co.

City or town

Best Gate RFD 1 Box 33

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

42 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Harris

4. Sex

F C Widow

5. Color of face

(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

John Harris

7. Birth date of deceased (mo., day, yr.)

March 1 1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

A A Co. Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Charles Simon

MOTHER FATHER

12. Name

Charles Simon

13. Birthplace

A A Co. Md.

14. Maiden name

Allen

15. Birthplace

A A Co. Md.

16. Informant

James Weems

Address

Best Gate RFD 1 Box 33

17. Burial

Date thereof July 23 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Fowlers Chapel

Location

Best Gate

18. Funeral director

T A Maedry & Son

Address

Solomons Island

19. Date rec'd by registrar

July 22 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

A A

City or town

Best Gate RFD 1 Box 33

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13 1948 to July 20 1948

and that I last saw her alive on July 20 1948

Immediate cause of death

Gastroenteritis - Cardiac -

Due to: Vascular Disease

DURATION

19

Due to:

Cardiac Malfunction

5 Days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

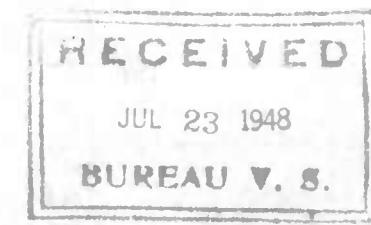
Means of injury

Injured at work?

23. SIGNATURE

Albert L. Anderson, M.D.

Address: Annapolis, Md. Date signed: July 22, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06883

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel Co.

City or town..... Skidmore, near Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

Skidmore, near Annapolis

How long in hospital or institution?.....

3. (a) FULL NAME

Vachel Asbury Harris

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Married

6.(b) Name of husband or wife..... Amelia Harris

7. Birth date of deceased (mo. day, yr.) March 26, 1892

8. AGE: Years Months Days If less than one day
56 3 22 hrs. min.9. Birthplace..... Skidmore, near Annapolis
(Town, county, and state)

10. Usual occupation..... Building Attendant

11. Industry or business..... None

12. Name..... Vachel Harris

13. Birthplace..... Skidmore, near Annapolis

14. Maiden name..... Louisa Colbert

15. Birthplace..... Skidmore, near Annapolis

16. Informant..... Amelia Harris

Address..... Skidmore, near Annapolis

17. Burial Date thereof..... 7-22-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Broad Neck

Location..... Skidmore, near Annapolis

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 43-45 Northwest Street

19. Date rec'd by registrar..... July 21, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Skidmore, near Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No...... Skidmore, near Annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7-18

19. 81 21 630 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-18-1948 to 7-18-1948

19. 81

19. 81

19. 81

and that I last saw her alive on 7-18-1948

Immediate cause of death

1) Hypertension Cardovascular
2) arteriole nephrosclerosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... G.T. Allen

M. D. or other.....

Address..... 10 Carroll Date signed..... 7-20-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

307
06884

28

Reg. Diat. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Fairmount Blv

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Dec. 1944

Hospital, institution, or street address where death occurred:

State Hospital

How long in hospital or institution?

Dec. 18th, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince George

City or town

718 Fairmount Blv

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

H A W K I N S, W A R R E N

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

c.

6. (b) Name of husband or wife

Julia Hawkins

7. Birth date of deceased (mo., day, yr.)

March 1st, 1908

6. (c) If alive, give age... years

8. AGE: Years

Months

Days

If less than one day

40

4

15

hrs. min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

MOTHER FATHER

12. Name

?

13. Birthplace

14. Maiden name

.

15. Birthplace

.

16. Informant

Julia Hawkins

Address

718 Fairmount Blv

Burial

Date thereof

7-19-48
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Payne Cemetery

Location

4600 Bergman Rd. N.E., D.C.

18. Funeral director

Myrtle R. Rollins

Address

4339 Hunt Pl. N.E. 264

19. July 16 1948

(Date rec'd by registrar)

E. F. Joyce

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 15th

19 48

at 6 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 18th, 1944 to 7-15-48

19 48

19 48

and that I last saw h. alive on 7-15-48

19 48

Immediate cause of death

Cachexia and

cachexia

Due to

Cachexia

general paralysis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

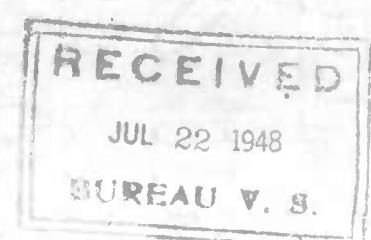
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06885

20

Reg. Dist. No.

1. PLACE OF DEATH:

County

Moreland

City or town

Franklin Mason Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Jane

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

DC

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

162 Holland Ter NE

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31 1948 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 July 1948 to 31 July 1948 and that I last saw her alive on 30 July 1948

Immediate cause of death

Acute Coronary Insufficiency 29 hrs

Due to Atherosclerotic Cardio-
vascular Disease

DURATION

29 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Sascer M.D.

Address Upper Marlboro, Md. Date signed 31 July 48

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 31, 1855

6.(c) If alive, give age years

8. AGE:

Years 13 Months 6 Days 0 If less than one day

hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

12. Name

George Fastray

13. Birthplace

Herman

14. Maiden name

Mary Eliza Burgess

15. Birthplace

Washington, D.C.

16. Informant

Elin M. F.

Address

162 Holland Ter, NE

17. Burial

Date thereof Aug 2 1948

(month) (day) (year)

Cemetery or crematory

Glenwood

Location

162 Holland Ter, NE

18. Funeral director

Riverside Md.

Address

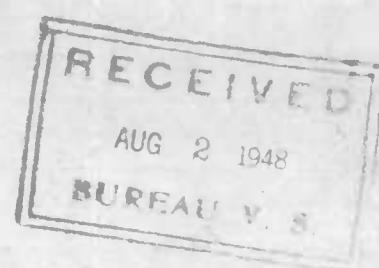
751 48

19. (Date rec'd by registrar)

19

Dr. C. C. Taylor

Registrar



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The first page of the death certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06886

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Anne ArundelCity or town West Shady Side
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 monthsHospital institution, or street address where death occurred: SameHow long in hospital or institution? Same

3. (a) FULL NAME

Elmer L. Dry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married6. (b) Name of husband or wife Marguerite W. Dry7. Birth date of deceased (mo., day, yr.) 60 March 10, 18888. AGE: Years 60 Months 4 Days 9 If less than one day

hrs.

min.

9. Birthplace Kansas City Mo
(Town, county, and state)10. Usual occupation Tax Consultant

11. Industry or business

12. Name Charles Dry13. Birthplace Massachusetts14. Maiden name Elizabeth Dry15. Birthplace Baltimore Md16. Informant Son - HusbandAddress 1833 Monroe St Md17. Burial Date thereof July 22-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemLocation 70th St. N.W. Wash.18. Funeral director The Drys Inc CoAddress 2901-14th St N.W. Wash D.C.19. Date received by registrar July 19, 1948Date signed J. B. Dent

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same County SameCity or town Same
(If outside city or town limits, write RURAL and give nearest town)Street No. Same
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 48 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

60 years 19 to 19 19and that I last saw h. alive on July 19 19 48Immediate cause of death Coronary Thrombosis DURATION one dayDue to NoneDue to NoneOther conditions Hurt Pelvis 1 year

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) None (County) None (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE A. J. Keil MD M. D. or other NoneAddress 1833-14th St. N.W. Wash. D.C. Date signed 7/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06887

846

28

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 9 mos.

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 yrs. 9 mos.

3. (a) FULL NAME

LUCILLE JAMES

4. Sex

female

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

unknown

8. AGE:

Years
33

Months

Days

If less than one day

hrs. min.

9. Birthplace

Alabama

(Town, county, and state)

10. Usual occupation

domestic

11. Industry or business

Eli James

12. Name

Alabama

13. Birthplace

Rilla Cotton

14. Maiden name

Alabama

15. Birthplace

Hospital Records

16. Informant

Crownsville, Md.

Address

Burial Date thereof 7-30-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hospital

Location

Crownsville

18. Funeral director

Suff Hospital

Address

Crownsville

19. July 30

Date rec'd by registrar

1948

E7 for fee Recd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Prince George's

City or town Tuxedo

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21

19 48, at 1:00a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 30 1941 to July 21 1948

and that I last saw her alive on July 21 1948

Immediate cause of death

Due to

Due to

Other conditions Schizophrenia, Paranoid Type

known to us since

10/30/41

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Pneumonia Hypostatic Pulmonis Dextri

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

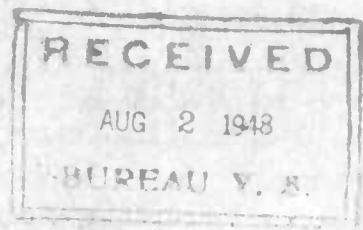
23. SIGNATURE

M. D. or other

Crownsville, Md.

Date signed 7/21/48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06888
46b

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County: Pasadena
 City or town: Pasadena
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, Institution, or street address where death occurred:
Nurs. Acre Green Haven

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: MD County: Anne Arundel
 City or town: Pasadena
 (If outside city or town limits, write RURAL and give nearest town)

Street No.: 116 (If rural, give LOCATION)

3. (a) FULL NAME
JOHN J. JARZYNSKI

3. (b) Social Security Number

4. Sex: M 5. Color or race: W. 6. (a) Single, married, widowed, or divorced: married

8. (b) Name of husband or wife: Mary

7. Birth date of deceased (mo., day, yr.): May 20th 1885 8. (c) If alive, give age: years

8. AGE: 63 Years 1 Months 20 Days If less than one day hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

12. Name: Henry Jarzynski

13. Birthplace: Poland

14. Maiden name: Mary Brackowska

15. Birthplace: Poland

16. Informant: Mrs. Mary Jarzynski

Address: Nurs. Acre Pasadena Md.

17. Burial: Burial Date thereof: July 26-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: Bernard Hill Rd

18. Funeral director: John J. Connolly

Address: 418 Eastern Ave.

19. 7/24 1948 Rec'd by registrar: Reg. B. C. W. Registrar: John J. Connolly
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 1947 to July 21, 1948

and that I last saw him alive on July 21, 1948

Immediate cause of death: Carcinoma of
Stomach

DURATION: 2 years

Due to: _____

Due to: _____

Other conditions: _____
 (Include pregnancy within 8 months of death)

Major findings of operations: _____

Date of op.: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

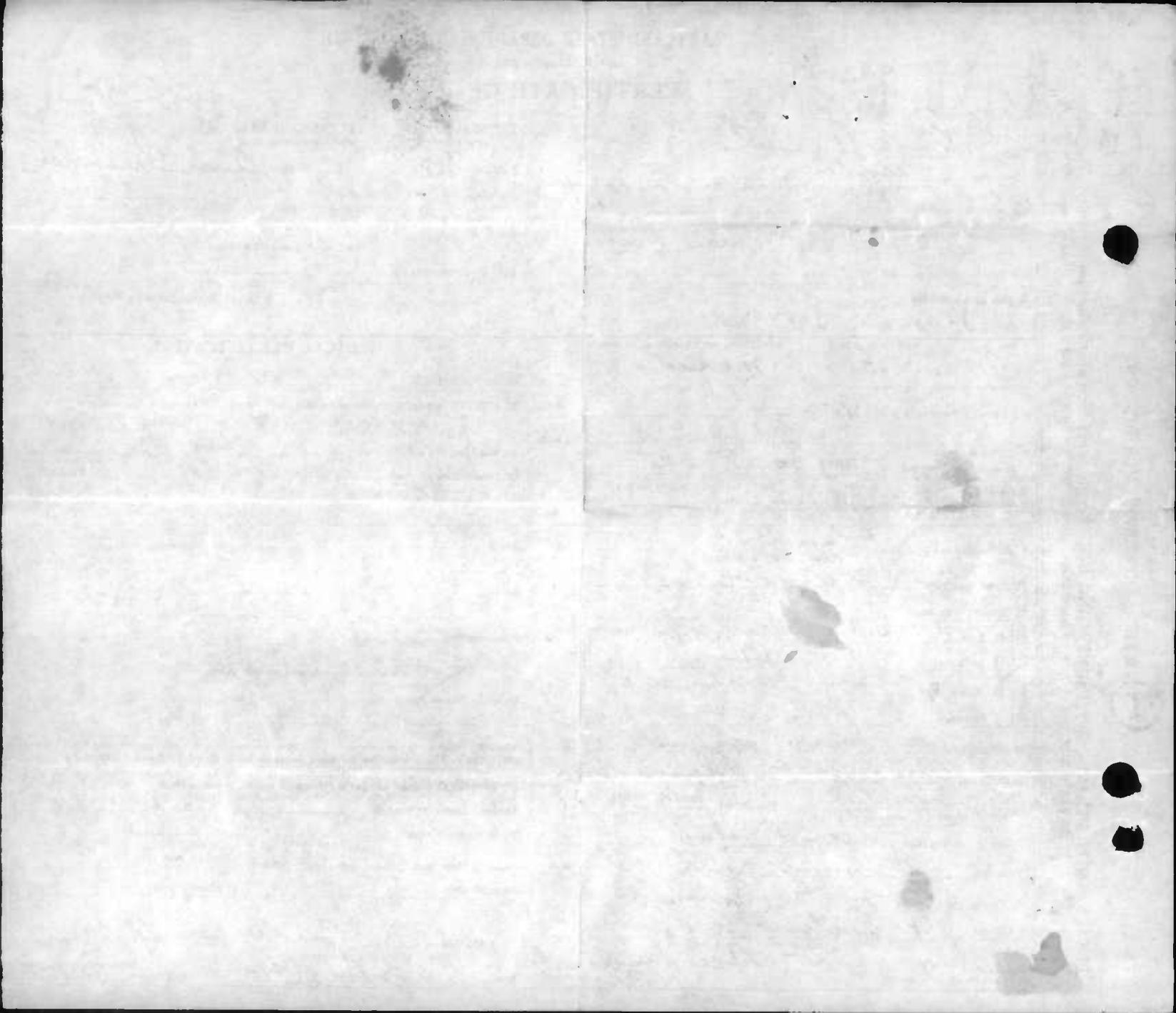
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured of home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: J. Brady Smith, M.D. M. D. or other: _____

Address: Riverside, Maryland Date signed: 7/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138
06889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel
Mayo

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Benjamin Joyce

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

Col

Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

1895

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

53

9. Birthplace.....

(Town, county, and state)

Mayo

10. Usual occupation.....

Cysterman

11. Industry or business.....

Unknown

MOTHER

FATHER

12. Name.....

Unknown

13. Birthplace.....

"

14. Maiden name.....

Joyce

15. Birthplace.....

Mayo

16. Informant.....

Solomon Nichols

Address.....

Mayo

17. Burial, cremation, or removal. If there is

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date read by registrar.....

(Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State.....

Md

County.....

City or town.....

Mayo

Street No.....

Md

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

330-09-5983

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22

10:48, af 12³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6, 1948, to July 22, 1948, in

and that I last saw him alive on July 22, 1948.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

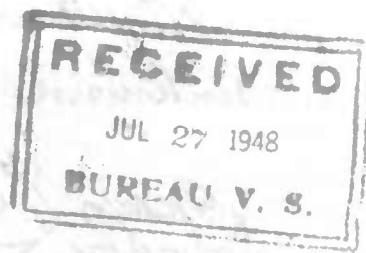
Dr. R. B. Richardson

M. D. or other

Address.....

110-8th St., Annapolis, Md. Date signed 7/23/48

2681
EG
8431



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06890

94a

23

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... A.A. Co.

City or town..... Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Julia J. Klemkowsky

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Walter

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

1873

8. AGE:

75

Years

Months

Days

If less than one day

..... hrs.

..... min.

9. Birthplace.....

Poland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

Peter Tylecka

13. Birthplace.....

Poland

14. Maiden name.....

15. Birthplace.....

Poland

16. Informant.....

Dr. Irvin Klemkowsky

Address

3833 Clifton Ave

17. Burial

Date thereof July 12-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Holy Rosary

Location.....

Balto. Co. Md

18. Funeral director.....

Wm. S. Fialkowski

Address

2007 Eastern Ave

19. (Date rec'd by registrar)

July 9, 1948 A. W. Gedick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Anne Arundel

City or town..... Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4601

Baltimore Highway

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8

1948, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1948, to Feb. 19, 1948, and that I last saw her alive on July 6, 1948.

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. J. Grimaldi, M.D.

M. D. or other

Address

4609 G St. N.E. Washington, D.C.

July 9, 1948

1881
1948

PLEASE WRITE PLAINLY, IN INDIA UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06891

97

28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel

County.....

Crownsville

(If outside city or town limits, write RURAL and give nearest town)

9 mos.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?

9 mos.

3. (a) FULL NAME

CHARLES MACLEOD

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Daisy Macleod

7. Birth date of deceased (mo., day, yr.)

1888

6. (c) If alive, give age years

8. AGE:

Years
60

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chesterfield, South Carolina

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

MOTHER FATHER

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant

Hospital Records

Address

Crownsville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/30/48

(month) (day) (year)

Cemetery or crematory

Mt. Auburn

Location

Md.

18. Funeral director

Ges. H. Kelson

Address

1303 Pressman St

19. (Date rec'd by registrar)

7/29

19 X

Sw. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1105 N. Gilmor St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27

19 48 1:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 19 47 to July 27 19 48

and that I last saw him alive on July 27 19 48

Immediate cause of death General Arteriosclerosis known to us since 10/17/47

Due to

Due to

Other conditions Psychosis with Cerebral Arteriosclerosis known to us since 10/17/47
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Jacob Mangerup, M.D.

7/27/48

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06892

Reg. Dist. No. 22

1. PLACE OF DEATH:

County..... A.A.
City or town..... Jessups, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 days

Hospital, Institution, or street address where death occurred:

Hospital, Md. House Correction.
In Hospital 9 days.

How long in hospital or institution?

3. (a) FULL NAME

GEORGE MARTIN

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife..... None

7. Birth date of deceased (mo., day, yr.) March 14, 1888.

8. AGE: Years 60 | Months 4 | Days 2 | If less than one day - - - hrs. - - - min.

9. Birthplace..... New York.
(Town, county, and state)

10. Usual occupation..... - - -

11. Industry or business..... - - -

12. Name..... Unknown
FATHER | 13. Birthplace..... ??14. Maiden name..... ??
MOTHER | 15. Birthplace..... ??

16. Intertant..... Md. House Correction.

Address..... Jessups, Maryland.

17. Burial (Burial, cremation, or removal, which)..... Burial Date thereof..... Aug 3, 1948
(month) (day) (year)

Cemetery or crematory..... Cherry Hill

Location..... Jessups, Md.

18. Funeral director..... N. L. Collins

Address..... Jessups, Md.

19. Aug 2, 1948
(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Annie Arundel

City or town..... Jessups (If outside city or town limits, write RURAL and give nearest town)

Street No..... Md. House of Correction
(FORMER RESIDENCE UNKNOWN)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1948, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 7, 1948, to July 16, 1948, and that I last saw him alive on July 16, 1948.

Immediate cause of death..... Uremia
DURATION.....Due to..... Chronic Nephritis
DURATION.....

Due to.....

Other conditions..... Myocardial degeneration
DURATION.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. - - -

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

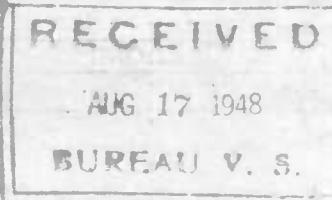
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... John A. Clark, M.D. M. D. or other

Address..... M.H.C. Jessups, Md. Date signed 7-16-48.



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

CERTIFICATE OF DEATH

Reg. Dist. No.

06893

1. PLACE OF DEATH A. A.
 County Hanover
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life-time
 Hospital, institution, or street address where death occurred: Dorsey-Harman's Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County A.
 City or town Hanover
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Worsey-Harman's Rd.
 (If rural, give LOCATION)

3. (a) FULL NAME Gladys V. Matthews
 4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) January 23, 1910 6. (c) If alive, give age years
 8. AGE: Years 38 Months 6 Days 27 If less than one day hrs. min.
 9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation At Home
 11. Industry or business None
 FATHER 12. Name Samuel E. Matthews
 13. Birthplace Md.
 MOTHER 14. Maiden name Annetta Lomack
 15. Birthplace Md.
 16. Informant Samuel E. Matthews
 Address Dorsey-Harman's Rd.
 BURIAL 17. Burial At Rest Cemetery Date thereof 7-22-48
 (Burial, cremation, or removal, when?) (month) (day) (year)
 Cemetery or crematory At Rest Cemetery
 Location Harman's, Md.
 18. Funeral director Most Reverend A. Hensley
 Address 578 W. Biddle St.
 19. 19. (Date rec'd by registrar) Registrar

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 3 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1948 to July 20 1948, and that I last saw her alive on July 19 1948. Immediate cause of death Common Cold + DURATION 1 wk.
 Pulmonary Congestion
 Due to.....
 Due to.....
 Other conditions Epilepsy 15 yrs
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Frank Shigley M.D. M. D. or other 7/20/48
 Address Savage, Md. Date signed 7/20/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

06894

93d

1. PLACE OF DEATH:

County A. A. County
 City or town Magothy - River
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna Maurer4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Rudolph Maurer7. Birth date of deceased (mo., day, yr.) MAY 28-1874 6. (c) If alive, give age 74 years8. AGE: Years 74 Months 2 Days 3 If less than one day — hrs. — min.9. Birthplace Germany (Town, county, and state)10. Usual occupation At Home11. Industry or business Widow12. Name Widow13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Julius C. MaurerAddress 3606 Wilkens Ave17. Burial, cremation, or removal? Burial Date thereof Aug 3-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boulevard ParkLocation Baltimore Md.18. Funeral director F.B. WibpertAddress 1300 Eatow Ph19. Date rec'd by registrar August 3, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CityCity or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)Street No. 3606 Wilkens Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 2:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1948 to July 28 1948 and that I last saw her alive on July 28 1948

Immediate cause of death

artery sclerosis cardiac disease?

DURATION

daysDue to HypertensionCardiac Hypertrophy

Due to

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE Carey Rootling

M. D. or others

Address 1326 W Lombard St Date signed 8/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

06895

28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
2 hours

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Chas. Mc Alexander Jr.

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

July 9th 1930

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Denver, Colo.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Charles Mc Alexander Jr.

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Mr. W. C. Morree

Address.....

3211 Varnum St Mt Rainier Md.

removal.....

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

Kansas City Mo

18. Funeral director.....

John M. Taylor Son

Annapolis Md.

Address.....

July 26 1948

(Date rec'd by registrar)

E. F. Joyce

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For all born infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination and that I last saw him alive on July 25 1948

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Drowning

Injured at work?.....

No

John M. Gaffey M.D. Medical

Examiner

Annapolis, Md.

Date signed

July 28 1948

RECEIVED

JUL 29 1948

BUREAU V. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06896

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Whitney Landing Rd.

How long in hospital or institution?

3. (a) FULL NAME

GEORGE CLYDE MITCHELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

Katie Mitchell

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) April 18, 1872

8. AGE: Years 76 Months 3 Days 0 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Unknown

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant Mr. Vincent A. Kaemmer,

Address Whitney Landing Road, Md.

17. Burial Date thereof 7/21/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory Mt. Olivet Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Date rec'd by registrar July 21, 1948 a.m. 8:00 a.m.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Ma.

State

County

City or town

Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Whitney Landing Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10, 1948, to July 18, 1948

and that I last saw him alive on July 18, 1948

Immediate cause of death Congestive

Heart Failure

DURATION

Due to Arteriosclerosis Generalized

Due to UNKNOWN

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry F. Zangara, M.D.

M. D. or other

Address Glen Burnie Md Date signed 7/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06897

CERTIFICATE OF DEATH

23

Reg. Dist. No. 93d

1. PLACE OF DEATH:

County Anne ArundelCity or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.Hospital, Institution, or street address where death occurred: # 10 Oak Lane S. W.

How long in hospital or Institution?

3. (a) FULL NAME

Sarah Elizabeth Perkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleW.WidowedWm W. Perkins

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Feb. 6 - 1848

8. AGE:

Years

Months

Days

11 less than one day

100510hrs.min.9. Birthplace Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County Anne ArundelCity or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Oak Lane - S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 16 1848

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 40 to July 16 1848and that I last saw her alive on July 16 1848

Immediate cause of death

Cardio-Vascular D.

Due to

arterios. sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Habits

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. A. Bass Jr.

M. D. other

Address Glen Burnie Date signed 7-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect, age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06898

61

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel

City or town

North Severn Naval Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Cooper Peterson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Paul C. Peterson

7. Birth date of deceased (mo., day, yr.)

Feb. 25, 1874

6. (c) If alive, give age years

8. AGE:

Years 74 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace

Montgomery Co., Md.

10. Usual occupation

11. Industry or business

MOTHER FATHER

Name Elijah Cooper

13. Birthplace

Unknown

14. Maiden name

Mary Ann Cooper

15. Birthplace

Unknown

16. Informant

Mary E. Feldmeyer

Address

North Severn Naval Station

17. Burial

Date thereof July 9th 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Bluff Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Laffey & Son

Address

Annapolis, Md.

19. Date rec'd by registrar

July 8 1948

19. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town North Severn Naval Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rifle Range at station

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 8 1948 8-15 p.m.

21. I CERTIFY that death occurred on the date above stated: Well attended deceased

Postmortem Examination
and that last saw him alive on July 6, 1948

Immediate cause of death

Due to Diabetes Mellitus 4920

Book Arterio. sclerosis

cystic

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

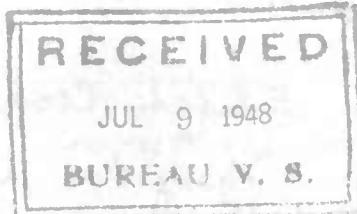
Means of injury

Injured at work?

23. SIGNATURE

John M. Laffey M.D. Examiner
Anne Arundel Md. Date signed 7-6-48

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06899

93d

21

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

Anne Arundel

County

Parole

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Richard Phillips

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Widower

Mary Phillips

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1878

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

69

7

12

hrs.

min.

9. Birthplace

(Town, county, and state)

Anne Arundel Co., Md.

10. Usual occupation

Laborer

11. Industry or business

Charles Phillips

MOTHER FATHER

12. Name

Id.

13. Birthplace

Laborer

14. Maiden name

Mary Gray

15. Birthplace

Md.

16. Informant

Richard Phillips, Jr.

Address

Parole, Md.

Burial

(Burial, cremation, or removal. Which?)

Date thereof August 5, 1948
(month) (day) (year)

Franklin Cemetery

Cemetery or crematory

Churchton, Md.

18. Funeral director

J. B. Johnson

Address

Annapolis, Md. P. O. Box 462

19. Aug. 5 48

(Date rec'd by registrar)

M. B. Finch
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Anne Arundel

Parole

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 31

1948 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....to.....19.....

and that I last saw him alive on July 31, 1948.

Immediate cause of death Apoplexy

DURATION

Due to Hypertensive Cardio-Vascular 2 wks

Diseases

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

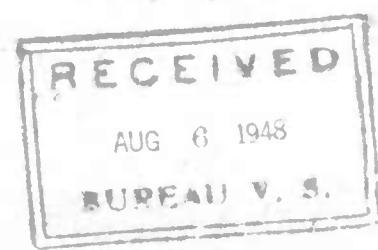
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 8/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

06900

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Hale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida Phipps

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Dean Phipps

7. Birth date of deceased (mo., day, yr.)

May 35. 1862

6. (c) If alive, give age years

8. AGE:

86 Years 1 Months 39 Days

It less than one day hrs. min.

9. Birthplace

Chesapeake Md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Joseph Randall

12. Name

Joseph

13. Birthplace

Chesapeake

3rd

14. Maiden name

Virginia Randall

3rd

15. Birthplace

Chesapeake

3rd

16. Informant

Marion B. Phipps

Address

Burial Hale

17. Burial

Date thereof July 26 1948

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Sherbert

Location

Hale

18. Funeral director

J. G. Stansbury

Address

Galesville Md.

19. Date recd by registrar

July 25 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

A.C.

City or town

Hale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Hale

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1948 to July 24 1948 and that I last saw her alive on 22 July 1948

Immediate cause of death

Generalized Asthma - Severe

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Jasmer

M. D. C. 26

Address Upper Marlboro Md Date signed 25 July 48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

06901

27

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Fort Geo G. Meade, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Fort Geo G. Meade, Md.

How long in hospital or institution?

3. (a) FULL NAME

DONALD ARTHUR PLUMMER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 3-17-1929

6. (c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
19	4	11	hrs. min.

9. Birthplace..... Sidman, Penna. (Town, county, and state)

10. Usual occupation..... Soldier

11. Industry or business..... Oliver William Plummer

12. Name..... Oliver William Plummer

13. Birthplace..... Penna.

14. Maiden name..... Unknown.

15. Birthplace.....

16. Informant..... Service Record

Address..... Fort George G. Meade, Md.

17. Removal..... Date thereof..... 30 July 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... Sidman, Penna.

18. Funeral director..... Unknown.

Address.....

19. 30 July 48
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Penna. County..... Cambria

City or town..... Sidman

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Rt #1 Box 69

(If rural, give LOCATION)

2.(a) If veteran, name war..... SOLDIER

3. (b) Social Security Number

* * *

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 28 July 1948 at 1000A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... crushing injury of

brain..... DURATION.....

Due to..... crushing of skull

Due to.....

Other conditions..... None

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 28 July 48

Where did injury occur?..... Ft G G Meade Md AA Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Army Post

Means of injury..... tree trunk Injured at work? Yes

fell on head when armored car struck same.

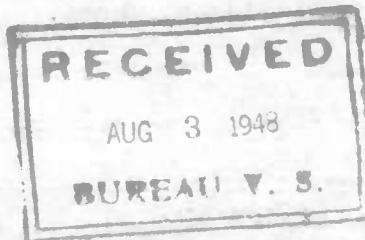
23. SIGNATURE..... Dale T. Millns 1st Lt. M. D. or other MC

Address..... James N. George, Jr. MC Sta Hosp Ft Meade Md

Date signed..... 29 July 48

LI-8-62b1
1929-17

82-6-84b1
82-28





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06902

846

Reg. Dist. No. 26

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

14 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?

14 days

3. (a) FULL NAME

ROLAND PRICE

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

May Price

6. (c) If alive, give age. — years

7. Birth date of deceased (mo. day, yr.)

April 25, 1906

8. AGE:

42

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Worked at Maryland Drydock

11. Industry or business

MOTHER FATHER

William Price

Maryland

Marceline Haywood

Maryland

16. Informant

Hospital Records

Address

Crownsville, Md.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof July 10, 1948

(month) (day) (year)

Mt. Calvary Cemetery

Cemetery or crematory

Ann Arundel County

18. Funeral director

Charles G. Cooper

Address

512 N. Carrollton Ave.

19. 7-8, 48

(Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 536 N. Bond

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

July 6

19 48 a 9:35 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 22

19 48 to July 6 19 48

and that I last saw him alive on

July 6

19 48

Immediate cause of death Exhaustion due to

Schizophrenia

known to us since

DURATION

6/22/48

Due to

Due to

Other conditions Schizophrenia - Catatonic Type

known to us since

6/22/48

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Crownsville, Md.

7/6/48

Address

Date signed

2010
Page

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06903

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County: Annapolis
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 2wks 7 3days
 How long in above place of death?
 Hospital, institution, or street address where death occurred: Emergency Hospital
 How long in hospital or institution? 2 wks & 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland State: Anne Arundel County
 City or town: Edgewater, Maryland (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Edgewater, Maryland
 (If rural, give LOCATION)
 2.(a) If veteran, name war:

3. (a) FULL NAME: Harry Randall

3. (b) Social Security Number

4. Sex: Male	5. Color or race: Colored	6.(a) Single, married, widowed, or divorced: Married
--------------	---------------------------	--

6.(b) Name of husband or wife: Martha Randall
 7. Birth date of deceased (mo., day, yr.): July 4, 1897

6.(c) If alive, give age: 49 years

8. AGE: 51	Years	Months	Days	If less than one day
		0	24	hrs. min.

9. Birthplace: Harwood, A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

12. Name: John Randall

13. Birthplace: Anne Arundel, Co. Md.

14. Maiden name: Elizabeth Davis

15. Birthplace: Anne Arundel Co. Md.

16. Informant: Martha Randall

Address: Edgewater, Maryland

17. Burial: Date thereof: July 31, 1948
 (Burial, cremation, or removal. Which?) Cemetery or crematory: Chews Chapel Cemetery

Location: Owenville, A.A.Co. Md.

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Date rec'd by registrar: July 30, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH: July 28, 1948, at 5:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1948, to July 28, 1948, and that I last saw him alive on July 28, 1948.
 Immediate cause of death: cerebral hemorrhage
 Due to: arterioclerosis
 Due to: ?
 Other conditions: ?
 (Include pregnancy within 3 months of death)

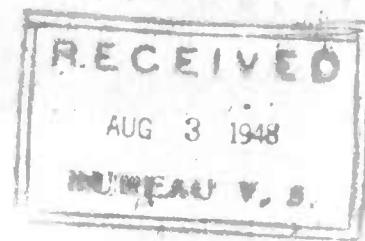
Major findings or operations: ?

Date of op.: ?
 Autopsy results: ?
 PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: ? Date of: ?

Where did injury occur? (City or town): ? (County): ? (State): ?

Injured at home, farm, industry, public place (where?): ?
 Means of injury: ? Injured at work? ?23. SIGNATURE: M. J. Klevans, M.D. or other
 Address: Annapolis Date signed: 7/29/48

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06904

CERTIFICATE OF DEATH

926
Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Glen Burnie, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Cyril Robert (Bob) Reynolds

3. (b) Social Security Number

NONE

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male..... White..... Married

6.(b) Name of husband or wife..... Margaret Reynolds

(Nee Luke)

6.(c) If alive, give age..... 43 years

7. Birth date of deceased (mo., day, yr.)..... February 3, 1896.

8. AGE: Years..... Months..... Days..... If less than one day
52..... 4..... 29..... hrs..... min.9. Birthplace..... Bird Island, Minn.
(Town, county, and state)

10. Usual occupation..... Body & Fender Repair

11. Industry or business..... Own Business

FATHER 12. Name..... Frederick Reynolds

MOTHER 13. Birthplace..... Minnesota

14. Maiden name..... Louella Lentz

15. Birthplace..... New York

16. Informant..... Margaret Reynolds

Address..... 413 Gov. Ritchie Highway Glen Burnie

17. Burial..... Date thereof..... July 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Glen Haven

Location..... Glen Burnie, Md.

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Md.

19. 7/5..... 1948..... Z. J. De Alba

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Anne Arundel

City or town..... Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 413 Gov. Ritchie Highway

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 2, 1948, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 to July 12, 1948
and that I last saw him alive on July 11, 1948.

Immediate cause of death.....

Acute anoxia and
insufficiency
of vital insufficiency

Due to.....

DURATION

One day

Due to.....

" "

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

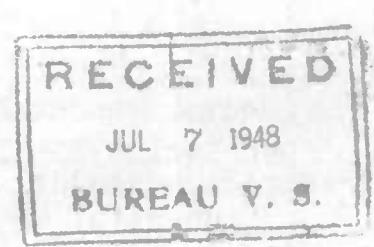
Means of injury.....

Injured at work?

23. SIGNATURE..... Gustave H. Faubert M.D.

M. D. or other

Address..... Glen Burnie, Md. Date signed..... 7/3/48



159
06905
death
Reg. Dist. No. 21

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County A. D. C.
City or town Gambrells, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution: Home
Length of mother's stay in County 6 years
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County A. D. C.
City or town Gambrells, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Davis's Esso Station
(If RURAL give LOCATION)

3. Name of child

5. Sex Male | 6. Twin or triplet —

FATHER OF CHILD

8. Full name James Ridgley
9. Color C 10. Age at time of this birth 43 yrs.

11. Usual occupation Farmer

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
(b) How many other children were born alive but are now dead? 1 (c) How many other children were born dead? 2

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None

(b) Induced? No

20. (a) Was there an operation for delivery? None
(Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? —

During operation? —

23. (a) July 20 1948 (b) Date thereof 7-20-1948
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Tabor

24. (a) Funeral director —
(b) Address Chesterfield, Md

MOTHER OF CHILD

12. Full maiden name Alice Queen
13. Color C 14. Age at time of this birth 23 yrs.
15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Prematurity Cause unknown
(b) Maternal causes —

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Edward J. Bennett, M. D.
(Specify if M. D., midwife, or other)

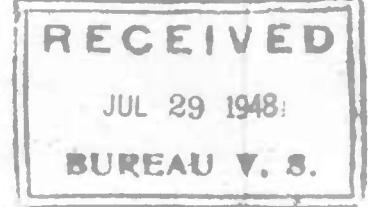
Address Gambrells, Md

25. (a) 7/28/48 (b) —
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per —

* See Instruction C on stub.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

06906

Reg. Dist. No.

21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Minute

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution? One Minute

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 935 Boucher Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary Schofield

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 27, 1948

8. AGE: Years

Months

Days

If less than one day

Newborn

hrs.

One

min.

9. Birthplace

Annapolis, Md.

(Town, County, and state)

10. Usual occupation

none

11. Industry or business

John J. Schofield

MOTHER FATHER

12. Name

John J. Schofield

13. Birthplace

Elizabeth, N.J.

14. Maiden name

Mary V. Taylor

15. Birthplace

Annapolis, Md.

16. Informant

John J. Schofield

Address

Eastport, Md.

17. Burial

Burial, cremation, or removal. Which?

Date thereof July 28, 1948

(month) (day) (year)

Cemetery or crematory

Location

John J. Taylor, Son

18. Funeral director

Address

Annapolis, Md.

19. Date rec'd by registrar

July 28, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27

1948

3:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him alive on.....

Immediate cause of death

Hypoxia -
Pre-eclampsia

Due to

Puerperal Separating
Placenta

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M.D. or other

Date signed



EVIDENCE FOR CHANGE
OF AGE SHOWN ON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

HLM No. G 116 JUL 23 1948

CERTIFICATE OF DEATH

06907
28

Reg. Dist. No.

1. PLACE OF DEATH:

County... Elkne Crandell
City or town... Brownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months, 26 daysHospital, Institution, or street address where death occurred: Brownsville State HospitalHow long in hospital or institution? 3 months, 26 days

3. (a) FULL NAME

William Scott

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Colored married

6. (b) Name of husband or wife

Estelle Scott

7. Birth date of deceased (mo., day, yr.)

1899

8. AGE:

Years 49 Months 4 Days 2 If less than one day
hrs. 0 min. 0

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Hospital records

Address

Brownsville, Md
Bureau July 23, 1948

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

A. General Hospital Co

18. Funeral director

Address

A. H. Haldeman

19. (Date rec'd by registrar)

July 19, 1948
Baltimore
22 N. Charles St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CountyCity or town Brownsville (If outside city or town limits, write RURAL and give nearest town)Street No. 139 Winters Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17, 1948 1948 6:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 22nd 1948 to July 17th 1948and that I last saw him alive on July 17th 1948

Immediate cause of death

General pectoris

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Date signed.....

Annapolis 2769 - MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C
016908

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Wagner - Margarita

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence Aller Seward

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Harry M. Seward

7. Birth date of deceased (mo., day, yr.) Dec 19 - 1888

8. (c) If alive, give age years

8. AGE: Years 59 Months 7 Days - If less than one day hrs. min.

9. Birthplace Richmond Hill - S. J. N.Y.

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Florence Aller

13. Birthplace Brooklyn, N.Y.

14. Maiden name Catherine Lewis

15. Birthplace Farmington - Conn.

16. Informant Jane Seward Gatter

Address 3212 Wallbrook Ave

17. Cremation Date thereof July 21 - 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sound on Park

Location Baltimore, Md.

18. Funeral director Ellsworth Dunnacott

Address 3911 Liberty Heights Ave

19. July 21 1948 A.M. Federal

(Date rec'd by registrar)

VS A15

Reg. Dist. No. 21

Date signed 21 July 48

Address 53 Cornhill St., Annapolis, Md.

M. D. or other

Date signed 21 July 48

Address 53 Cornhill St., Annapolis, Md.

Date signed 21 July 48

Address 53 Cornhill St., Annapolis, Md.

Date signed 21 July 48

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Date signed 21 July 48

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Date signed 21 July 48

Address 53 Cornhill St., Annapolis, Md.

Date signed 21 July 48

I MARGIN RESERVED FOR BINDING

I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dwight H. Haskins, M.D.

M. D. or other

Address

53 Cornhill St., Annapolis, Md.

Date signed

21 July 48

Date signed

Salvans i
Horse)

Sylvester Salvans



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

06909

CERTIFICATE OF DEATH

Reg. Dlat. No. 25

1. PLACE OF DEATH

County

A.A. Co.

City or town

Brooklyn, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3.(a) FULL NAME

George Thomas Shead

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Minnie J. James

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

August 29, 1874

8. AGE:

Years
73

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Federal Reserve Bank

11. Industry or business

FATHER

12. Name

John Shead

13. Birthplace

Maryland

MOTHER

14. Maiden name

Hermilda Buck

15. Birthplace

Maryland

16. Informant

Mrs. Minnie J. Shead

Address

4934 Brookwood Rd

17. Burial

Date thereof 7/24/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Loudon Park

Location

Frederick Ave

18. Funeral director

John J. Henney Inc.

Address

915 Light St.

19. Date rec'd by registrar

7/31/48

19.

Sw. Pedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A.A. Co.

City or town

Brooklyn, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4934 Brookwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 21st 1948 at 12th A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/18/48 to 7/21/48

and that I last saw him alive on July 20/48

Immediate cause of death

chronic nephritis

Due to

senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel Rubin M.D.

M. D. or other

Address 203 Galapagos Ave Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

184

06910
20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 1, 1934

6. (c) If alive, give age.....years

8. AGE:

Years
15

Months

Days

If less than one day
.....hrs.min.

9. Birthplace

Mark. d. b.

(Town, county, and state)

10. Usual occupation.

School

11. Industry or business

MOTHER FATHER

12. Name

James P. Spindle

13. Birthplace

Poposetto, Virginia

14. Maiden name

Sally Roth

15. Birthplace

Pungo

16. Informant

Address

James P. Spindle

Deale Md

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

7/2/48

Cemetery or crematory

Voters Church

Location

-2

Loretto Virginia

18. Funeral director

Address

J. A. Daugherty & Son

Dealeville Md

19. (Date read by registrar)

7/2

19 48

M. M. Clayton
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For whom infants give residence of mother)

State

Maryland

County

Anne Brundel

City or town

Deale

Street No.

Deale Beach

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1

1948

7 20
M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination

and that I last saw him alive on

July 1

1948

Immediate cause of death

Bullet wound in
head entering left side
of nose.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Accident

Date of...

7/1/48

Where did injury occur?

Deale

(City or town)

Md

(State)

at home

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

no

22 cal. rifle

23. SIGNATURE

John M. Flaherty M.D.

Deputy
Medical

Examiner

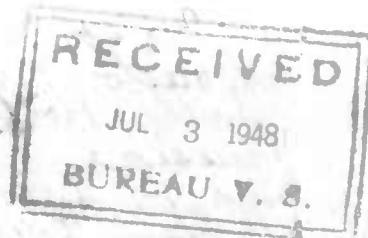
M. D. Examiner

Annapolis, Md

Date signed 7/1/48

Loretto, Va

Frank Spindler
Tappahannock



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

069121
Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

Wm. Arndel
Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

dead on arrival

Hospital, institution, or street address where death occurred:

Emergency Hospital Annapolis Md

How long in hospital or institution?

dead on arrival

3. (a) FULL NAME

Charles Louis Steinwedel

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

July 5. 1868

8. AGE:

Years

Months

Days

If less than one day

80

0

21

hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore City Maryland

10. Usual occupation

Retired

Cobbler

11. Industry or business

Charles Steinwedel

Fire Department

12. Name

Charles Steinwedel

Katherine Heiner

13. Birthplace

Baltimore Maryland

Katherine Heiner

14. Maiden name

Baltimore Maryland

Mrs. Kula Romoser

15. Birthplace

Baltimore Maryland

Mrs. Kula Romoser

16. Informant

John B. Steppert & Son

4202 Wilton Rd. Baltimore

17. Burial

Burial

(Burial, cremation, or removal, which?)

Date thereof.....

(month) (day) (year)

Date thereof.....

(month) (day) (year)

Date thereof.....

(month) (day) (year)

18. Cemetery or crematory

Cremated Park

Baltimore Maryland

19. Funeral director

John B. Steppert & Son

1200 Eastern Place

20. Address

Annapolis Maryland

21. (Date rec'd by registrar)

7/29/48

22. (Date)

1948

23. Registrar

John B. Steppert & Son

Annapolis Maryland

7-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

468
16912
16

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Anne Arundel
City or town Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

Patapsco

How long in hospital or institution?

3. (a) FULL NAME

James Bradford Thomas4. Sex Male 5. Color or race col 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lewis Thomas7. Birth date of deceased (mo., day, yr.) May 4 1880 8. (c) If alive, give age 71 years8. AGE: Years 68 Months 2 Days 8 Less than one day X hrs. min. 9. Birthplace Charles Co. Md (Town, county, and state)10. Usual occupation Laborer Farm R.R.11. Industry or business Retired12. Name Samuel Thomas13. Birthplace Charles Co. Md14. Maiden name Julia Anne Green15. Birthplace Charles Co. Md16. Informant DaughterAddress Box 468 Linthicum Heights Md17. Burial Date thereof 7-16-48 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or cemetery St. Augustine Cemt.Location W. Belvedere18. Funeral director A. BulleheadAddress 918. David Hill Av.19. (Date rec'd by registrar) 7-13-48 (Date signed) 7-13-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne ArundelCity or town Linthicum Heights (If outside city or town limits, write RURAL and give nearest town)Street No. Patapsco (If rural, give LOCATION)2.(a) If veteran, name war None

3. (b) Social Security Number

717-07-6538

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1948 at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 1948 to July 13 1948and that I last saw him alive on July 12 1948

Immediate cause of death

carcinoma stomach& secondary metastasis

Due to

Age advanced

Due to

Diarrhea

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations carcin of stomachDate of op. July 12 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B.B. Bradforth M. D. or other _____Address Sheridge Rd Date signed 7-13-48

I

VS A15
9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

0691340

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **Owensville, A.A. Co.**

County

City or town **Owensville**

(If outside city or town limits, write RURAL and give nearest town)

15 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Lillian Tucker4. Sex **F**

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Charles Thomas Tucker

7. Birth date of deceased (mo., day, yr.)

Dec. 14, 1870

6.(c) If alive, give age years

8. AGE: **77**

Years

Months

Days

15

If less than one day

hrs. min.

9. Birthplace **Calvert Co.**

(Town, county, and state)

10. Usual occupation.

11. Industry or business

Dove

MOTHER FATHER

12. Name

Dove

13. Birthplace

Eliza Ellen Dove

14. Maiden name

Calvert Co. Md.

15. Birthplace

16. Informant

Daisy T. Sutt

Address

Owensville, Md.

17. Burial

Date thereof **8/2/48**

(month) (day) (year)

(Burial, cremation, or removal. Which?)

**Friendship Methodist
Friendship, Md.**

Location

T.A. Hardesty & Son

18. Funeral director

Galesville, Md.

Address

8/2/48 *W.H. Taylor*
Registrar

19. (Date rec'd by registrar)

19.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.**A.A.**

State

County

City or town **Owensville**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

July 29

19 48 9.25 A.M.

2D. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23 1948 to *July 29* 1948
and that I last saw her ~~alive~~ alive on *July 29* 1948

Immediate cause of death

coronary occlusion

Due to

coronary disease

Due to

atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *W.H. Taylor, M.D.* M. D. or other

Address

7/31/48

Date signed

RECEIVED

AUG 3 1948

BUREAU V. S.

STATE
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

069121
Registered No. 21

2
The
margin reserved for binding
please write plainly, with unfading ink. Every item of information should be carefully supplied.
especially important. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: *Glen Burnie, Md.*
 (a) Baltimore City, Maryland
 (b) Street address *2nd & Crain, Md.*
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) *24 yrs*

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Md.* (b) County *Anne Arundel*
 (c) City or town *Glen Burnie*.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *Second Ave & Crain*.
 (If rural give location)
 (e) Citizen of foreign country? *Yes or No*
 If yes, name country

3 (a) FULL NAME *Mrs. Elizabeth L. Walter*
 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex *F* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced *Married*
 6 (b) Name of husband or wife *Henry M. Walter*
 6 (c) If alive, give age *50 years*

7. Birth date of deceased (mo., day, yr.) *Dec 20 1898*

8. AGE: Years *49* Months *6* Days *6* If less than one day
 hr. *0* min. *0*

9. Birthplace *Harford Co., Md.*
 (Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

12. Name *John Lloyd*

13. Birthplace *Harford Co. Md.*

14. Maiden Name *Mary Singleton*

15. Birthplace *Harford Co. Md.*

16 (a) Informant *Ellen C. Lloyd*
 (b) Address *3316 Ellerlie Ave*

17 (a) *Burial* (b) Date thereof *7-13-48*
 (Burial, cremation, or removal) (month) (day) (year)

18 (a) Cemetery or crematory *Gate Budge*
 Location *Delta, Pa.*

18 (a) Funeral director *Jack Lewis*
 (b) Address *2100 Eutaw Pl*

19 (a) *7/13* (b) *48 29. Leafer*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *7/13 1948* at *6:54* M

21. I certify that death occurred on the date above stated; that I attended deceased from *June 27, 1948* to *July 12, 1948* and that I last saw her alive on *7/12 1948*.

Immediate cause of death

Pulmonary Tuberculosis

Duration *16 yrs*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence at *M*
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)

(e) Means of injury

23. Signature *D. M. Shulman*
 Address *2426 Eutaw Pl* Date signed *7/13/48*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

06915

Reg. Dist. No.

21

1. PLACE OF DEATH: Anne Arundel

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 hours

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME Maggie L. Walton4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Thomas Walton7. Birth date of deceased (mo., day, yr.) Sept 29, 1883 6. (c) If alive, give age years8. AGE: Years 64 Months 9 Days 21 If less than one day hrs. min.9. Birthplace Baltimore (Town, county, and state)10. Usual occupation Housewife11. Industry or business W. M. Marquess12. Name William Marquess13. Birthplace Baltimore14. Maiden name B. M. Marquess15. Birthplace Baltimore16. Informant Thomas WaltonAddress 52 Calvert St. Annapolis17. Burial Date thereof July 21, 1948 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burial GroundsLocation Anne Arundel Co.18. Funeral director J. A. Hardisty & SonAddress Salisbury, Md.19. Date rec'd by registrar July 19, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number Serial 32111-48

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1948 at 4:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1947 to July 8, 1948 and that I last saw her alive on July 8, 1948Immediate cause of death coronary diseaseand general condition angina pectorisDue to coronary diseaseDue to coronary diseaseOther conditions general

(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

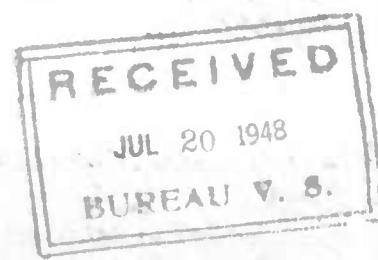
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE George C. Bozell M. D. or other PhysicianAddress Annapolis, Md. Date signed July 18, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06916

183

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

Severn River

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Francis Joseph Wanex

3. (b) Social Security Number

4. Sex

Male M.

5. Color or race

Single

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov 26 1929

6. (c) If alive, give age years

8. AGE:

Years 18 Months 7 Days 30 If less than one day hrs. min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Clerk at C. S. P. Store

11. Industry or business

Annapolis Md.

12. Name

Frank J. Wanex

13. Birthplace

Maryland

14. Maiden name

Margaret Rogicka

15. Birthplace

Baltimore

16. Informant

Frank J. Wanex

Address

519 Burnside Ave. Eastport

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 29 1948

(month) (day) (year)

Cemetery or crematory

St. Marys

Location

Annapolis Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis Md.

19. Date rec'd by registrar

July 28 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A.A.

City or town

Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

519

Burnside Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 25 1948 at 9th P.M.

21. I CERTIFY that death occurred on the date above stated; the deceased was in good health and well until about

Postmortem Examination

and died on July 27 1948

and that death occurred on

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 7-25-48Where did injury occur near Worcester Anne Arundel Maryland (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Severn RiverMeans of injury Drowning Injured at work? no23. SIGNATURE John M. Gaffey, M.D. M.D. or other Medical ExaminerAddress Annapolis, Maryland Date signed 7-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1336

06917

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel Co.

City or town

Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital institution, or street address where death occurred:

Emergency Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Lillie B. May

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John May

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 20th 1890

8. AGE:

Years

Months

Days

If less than one day

57

10

2

.hrs.

min.

9. Birthplace

(Town, county, and state)

Jersey

10. Usual occupation

Home wive

11. Industry or business

James Brown

12. Name

James Brown

13. Birthplace

Jersey

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

John May

Address

Severna Park, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Cremation

Cemetery or crematory

Glen Haven Memorial

Location

Glen Burnie, Md.

18. Funeral director

John M. May, Esq., Son

Address

Annapolis, Md.

19. Date rec'd by registrar

July 24, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22

1948 at 11:00 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 19

1948

to July 22 1948

and that I last saw her alive on July 21, 1948

1948

Immediate cause of death

Acute Pyelonephritis

(or pern nephritis abscess)

old bloodclot kidney

Due to

Other conditions

Cystitis & distorted & multiple arteries - yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Anna Maria Klawans, Md.

Date signed July 24, 1948

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

488
06918
21

Reg. Dist. No.

1. PLACE OF DEATH:

County ANNE ARUNDEL
 City or town RIVIERA BEACH
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

BESSIE M WEIBE4. Sex Female 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife OTTO WEIBE SR7. Birth date of deceased (mo., day, yr.) APRIL 25, 18888. AGE: Years 60 Months Days If less than one day hrs. min. 9. Birthplace MARYLAND (Town, county, and state)10. Usual occupation H.W.

11. Industry or business

12. Name GEORGE CARSON13. Birthplace MD14. Maiden name LILLIAN PERRY15. Birthplace MD16. Informant MR OTTO WEIBE JRAddress HARLEM RD RIVIERA BEACH17. BURIAL Date thereof JULY 27 '48 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LOUDON PARKLocation 3801 EDMUNDSON AVE18. Funeral director Nancy H. W. L. Inc.Address 4104 EDMUNDSON AVE19. (Date rec'd by registrar) 7/26/48 19. (Date) 7-26-48 Rev. Heberlin

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ANNE ARUNDELCity or town RIVIERA BEACH (If outside city or town limits, write RURAL and give nearest town)Street No. HARLEM RD (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 23 1948 at21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 to July 25 1948 and that I last saw her alive on July 23 1948.Immediate cause of death Catarrhal of interstitial DURATION 6 daysDue to Due to Other conditions (Include pregnancy within 3 months of death)Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Thos. J. Phillips M. D. or other Address 3307 Edmonson 15th Date signed 7-26-48

1948

1881

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 06919

131a

1. PLACE OF DEATH

County Anne Arundel Co

Registration Dist. No. 21

Village or City New Severna Park

St.

Ward

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME Harold Edward West

(a) Residence: No.

Severna Park, Md

St. 2

Ward

(Usual place of abode)

If U. S. Veteran, specify WAR 21

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Widowed

Sa. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Maur West

6. DATE OF BIRTH (month, day, and year)

Mar. 14, 1866

7. AGE

81

Years

Months

8

Days

10

If LESS than

1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done as SPINNER, SAWYER, BOOKKEEPER, etc. *Patti Sewer Room
+ Reporter*

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. *Newspaper*

10. Date deceased last worked at this occupation (month and year) 1945

11. Total time (years) spent in this occupation *over 40 yrs*

12. BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

MOTHER FATHER

13. NAME *Harold Edward West*14. BIRTHPLACE (city or town)
(State or country) *Virginia*15. MATURE NAME *Mary Deans Williams*16. BIRTHPLACE (city or town)
(State or country) *Virginia*

17. INFORMANT

*William West**Severna Park, Md.*

18. BURIAL, CREMATION, OR REMOVAL

Place *Newtown, Severna Park* Date *July 27, 1948*

19. UNDERTAKER

Wm. Jackson & Son(Address) *Baltimore, Md.*

20. FILED

7/26 1948 Alvin Nederlich

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July
(Month)24
(Day)1948
(Year)

22. I HEREBY CERTIFY That I attended deceased from

June 10, 1948 to *July 24, 1948*I last saw him alive on *July 24, 1948*; death is said to have occurred on the date stated above, at *4:05 P.M.*

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

*Obstruction of heart & lungs*Date of onset *2 years*

Other Contributory Causes of importance:

Emphysema & hypertension

5 yrs

Name of operation *None* Date of *None*What test confirmed diagnosis *Symptom* Was there an autopsy? *No*

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? *No* Date of injury *None*Where did injury occur? *None*

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury *None*Nature of Injury *None*24. Was disease or injury in any way related to occupation of deceased? *No*If so, specify *None*(Signed) *James S. Bellinger* M. O.
(Address) *2000 Barksdale Rd.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

	Other contributory causes of importance:	
Gallstones	Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06920

93d
28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr. 1 mo. 19 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?..... 1 yr. 1 mo. 19 days

3. (a) FULL NAME

JENNIE WHITFIELD

4. Sex

female

5. Color or race

negro

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1885

6.(c) If alive, give age years

8. AGE:

Years
63

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

unknown

11. Industry or business

MOTHER FATHER

12. Name..... unknown

13. Birthplace

14. Maiden name..... unknown

15. Birthplace

16. Informant

Hospital Records

Address

Crownsville, Md.

17. Burial

Date thereof

July 20, 1940
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

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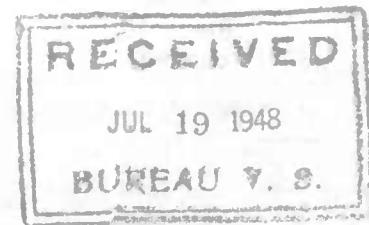
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06921

94a

20

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 60 yrs.

Hospital, institution, or street address where death occurred:

Central Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

BERNARD H. WILLIAMS, Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife.....

Martha D. Williams

6. (c) If alive, give age..... 53 years

7. Birth date of deceased (mo. day, yr.)

October 27, 1887

8. AGE:

Years
60Months
(60-8-5)Days
8Days
5

If less than one day

hrs. min.

9. Birthplace..... Davidsonville, A.A. Co., Maryland
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business..... Farming

12. Name..... John I. Williams

13. Birthplace..... Maryland

14. Maiden name..... Sally M. Hodges

15. Birthplace..... Maryland

16. Informant..... Mr. Bernard H. Williams, Jr.

Address..... Central Ave., Davidsonville, Maryland

17. Burial..... Date thereof..... July 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... All Hallows Cemetery

Location..... Davidsonville, Maryland

18. Funeral director..... Ben L. Hopping and Son

Address..... 170-172 West St. Annapolis, Maryland

19. (Date rec'd by registrar)..... 19.....
(Date rec'd by registrar)Carrie J. Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Davidsonville
(If outside city or town limits, write RURAL and give nearest town)Street No..... Hy-wayRt. #214
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 2, 1948, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... June 29, 1948, to July 2, 1948
and that I last saw him alive on July 1, 1948.

Immediate cause of death.....

Coronary occlusion

Due to..... coronary disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

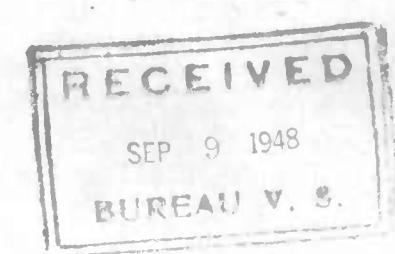
Means of injury.....

Injured at work?

23. SIGNATURE..... Bruce H. Wilson, M.D.

M. D. or other

Address..... Catherin, Md. Date signed 7/8/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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06922

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County Anne Arundel
 City or town Annapolis, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 Minutes
 Hospital, institution, or street address where death occurred: U.S. Naval Hospital, Annapolis, Maryland
 How long in hospital or institution? 35 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 701 Dreams Landing
 (If rural, give LOCATION)
 2.(a) If veteran, name war: —

3. (a) FULL NAME

BRENT THOMAS WILLIAMS

4. Sex Male 5. Color or race White-US 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife: —
 7. Birth date of deceased (mo., day, yr.) July 31, 1948
 8. AGE: Years 0 Months 0 Days 0 If less than one day hrs. 35 min.
 9. Birthplace Annapolis, Anne Arundel, Maryland
 (Town, county, and state)
 10. Usual occupation: —
 11. Industry or business: —
 12. Name of Father John E. Williams
 13. Birthplace Camden, New Jersey
 14. Maiden name Patricia Louise Barnes
 15. Birthplace Elkhorn, Wisconsin
 16. Informant John E. Williams
 Address 701 Dreams Landing, Annapolis, Md.
 17. Burial Date thereof 8-2-48
 (Burial, cremation, or removal. Which?) Naval Cemetery
 Cemetery or crematory
 Location Annapolis, Maryland
 18. Funeral director B.L. HOPPING AND SON
 Address 172 West St., Annapolis, Maryland
 19. Date rec'd by registrar August 2 1948

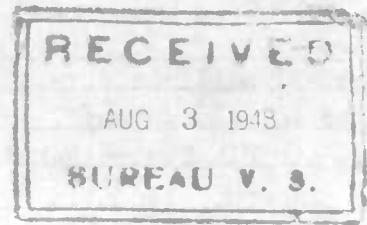
3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 July 1948 at 9:35a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9:00am 7-31-48 to 9:35a.m. 7-31-48 and that I last saw him alive on 31 July 1948.
 Immediate cause of death Pre-mature - 26wks gestation - Weight 2 1/2 lbs.
 DURATION 35 mins.
 Due to: —
 Due to: —
 Other conditions: —
 (Include pregnancy within 8 months of death)
 Major findings of operations: —
 Date of op.: —
 Autopsy results: —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: — Date of: —
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —
 23. SIGNATURE JESSE W. MILLER, Captain, U.S.N.C. or other
 Address U.S.N.H., Annapolis, Md. Date signed 7-31-48

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE UNITED STATES GOVERNMENT



Dr. Basile

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06923

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

W. Divorced

6.(b) Name of husband or wife

Sidney Shadden

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Nov 28th 1882

8. AGE:

Years

Months

Days

If less than one day

65 8 0 hrs. min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business

MOTHER

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Carvel Hotel 19 Geo St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 28 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1948 to July 28 1948 and that I last saw her alive on July 28 1948.

Immediate cause of death.....

Myocarditis, chronic & hyperkinetic suffusion

Due to.....

Cerebral emboli, cerebral

Due to.....

Bronchial asthma

Other conditions.....

Bronchitis.

DURATION

Several years

then years

then years

then years

then years

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

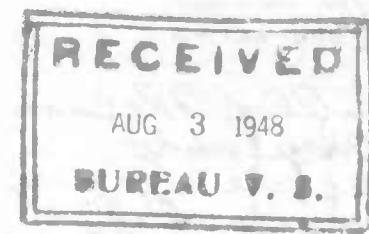
Means of injury.....

Injured at work?

23. SIGNATURE.....

George C. Bond M. D. or other

Address..... Annapolis 27 Date signed..... July 31, 1948



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06924

21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Anne Arundel*City or town *Eastport*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie M. Wiesenauer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female**White**Married*

6. (b) Name of husband or wife

John C. Wiesenauer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 31st 1878

8. AGE:

Years

Months

Days

If less than one day

*70**3**18**hrs.**min.*

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Ret painter U.S. Naval

11. Industry or business

Academy

12. Name

Martin B. Sch

13. Birthplace

Germany

14. Maiden name

Muhnauer

15. Birthplace

Muhnauer

16. Informant

John C. Wiesenauer

Address

422 Third St. Eastport Md

17. Burial

Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Glen Haven Memorial

Location

Glen Burnie Md.

18. Funeral director

Howard Evans

Address

1400 S. Charles St. Baltg Md.

Date rec'd by registrar

19. July 18 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

O. O.

City or town

Eastport

Street No.

422 Third St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 12 1948 to July 17 1948

and that I last saw her alive on

July 9 6 1948

Immediate cause of death

*coronary vascular or**hypertensive cardio-vascular**disease*

DURATION

18 hrs

Due to

*hypertensive cardio-vascular**disease**15 yrs*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

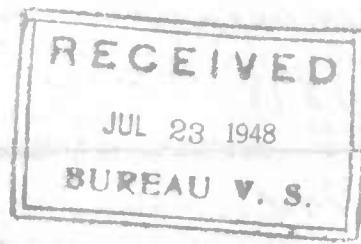
M. D. or other

Address

S. Borsuck M.D.

Date signed

7/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116925

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? dead on arrival

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age in years

Feb. 22nd 1888

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

New York City, N.Y.

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3814 Davis Place N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5

1948 2 55 P.M.

21. I CERTIFY that death occurred on the date above (a) ~~the postmortem report from~~~~Postmortem Examination~~ ~~July 5 1948~~

Immediate cause of death

Coronary occlusion

Due to

Coronary sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Inured at home, farm, industry, public place (where?)

Means of injury

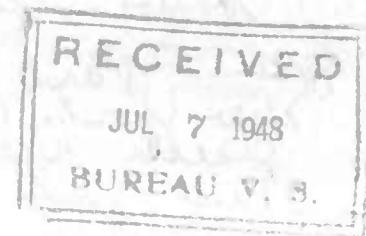
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06926

21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 daysHospital, institution, or street address where death occurred: Emergency HospitalHow long in hospital or institution? 8 days

3. (a) FULL NAME

Georgia A. Wright4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife JOHN WRIGHT7. Birth date of deceased (mo., day, yr.) JAN. 30, 18716. (c) If alive, give age years8. AGE: Years 77Months 5Days 11If less than one day hrs. min.9. Birthplace Gloucester Co., Va.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business —12. Name Benjamin Pratt13. Birthplace Phila, Pa.14. Maiden name UNKNOWN15. Birthplace —16. Informant MR. BENJAMIN H. PRATTAddress 3103 Mareco Ave - 1317. Burial Burial

(Burial, cremation, or removal, Which?)

Date thereof 7/14/48

(month) (day) (year)

Cemetery or Lorraine Cem.Location BALTO. MD.18. Funeral director Wm. T. Siegler & SonsAddress BALTO. MD.19. (Date rec'd by registrar) 7/13/4819. (Date rec'd by registrar) 7/13/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty Wic.City or town SHARPSTOWNStreet No. —

(If rural, give LOCATION)

2.(a) If veteran, name war No3. (b) Social Security Number No

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 11, 1948

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

June 10, 1948 to July 11, 1948and that I last saw her alive on July 11, 1948

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertensive arterioscleroticcardiovascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

EDPHEW

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. Peyton Kitching, M.D.

M. D. or other

Address Annapolis, Md. Date signed July 11, 1948

Registrar